SUMMARY

During the past decade there was significant improvement in some of the leading causes of hospitalization and death in California women. We found:

- A significant decline in death rates for heart disease and cancer. Nevertheless, these remained the leading causes of death for California women.
- A significant decline in the percent of women over age 50 who had never had a mammogram, as well as a significant decrease in mortality due to breast cancer.
- A significant improvement in the use of seat belts, as well as a significant decline in mortality due to motor vehicle accidents. Nevertheless, motor vehicle accidents remained the leading cause of death for girls and for women under age 35.
- A significant decline in mortality due to suicide.

Despite this progress, the data in this report also showed that the status of women's health declined in several areas from 1984 to 1994. For example, we found:

- A significant increase in the mortality associated with diabetes. We also found that diabetes-related mortality is more extensive than shown in most reports of mortality data because it usually is not listed as the first (underlying) cause of death in vital statistics records.
- A significant increase in the percent of women who were obese.
- A significant increase in mortality due to lung cancer.
- A significant increase in mortality due to AIDS.
- Elevated incidence of chlamydia: it was four times greater than that of gonorrhea. Incidence of chlamydia may be even higher since there is probably significant underdiagnosis and underreporting of the infection.

High Risk Groups

- **Southeast Asian Women**

  Southeast Asian women had high fertility rates combined with high teen birth rates, and high rates of late prenatal care. A large proportion of the births were paid for by Medi-Cal, which indicates that many of these mothers were poor. In addition, Asians as a group were more likely than other groups to have never received a mammogram or Pap test. Not receiving these screening exams puts them at higher risk for late diagnosis of breast or cervical cancer.

- **African American Women**

Among all women, African American women had the shortest life expectancy. They had the highest levels of mortality at every age, especially in infancy and young adulthood. They had the highest mortality from heart disease and stroke. They also had the highest prevalence of hypertension and obesity, two of the leading risk factors for cardiovascular disease.

African American women had the highest mortality rates for homicide and for AIDS. They also had the highest incidence of other sexually transmitted diseases (syphilis and gonorrhea). Relatively large proportions of African American women reported having incomes in the poverty range and limited education levels, especially the elderly.

- **Hispanic Women**

Hispanic women were least likely of all women to have any insurance coverage and least likely to begin prenatal care in the first trimester of pregnancy, although they had the highest fertility rates and largest family size. A high percent of the elderly Hispanic women had never received a mammogram. They were also more likely than any other group to have less than a high school education and more likely to use a language other than English at home. Together, these factors suggest that health education messages do not reach them easily.

- **Native American Women**

Health data that identify Native American women separately from other race/ethnic groups are limited (See below: Need For Further Study). However, the available information suggests that this is a high risk group. Among Native American women who gave birth during the period covered by this report, relatively large percentages were teens, had less than a high school education, began prenatal care late, and relied on Medi-Cal to pay for the birth. Findings from the risk factor survey suggest that Native American women have elevated risk of smoking, binge and chronic alcohol abuse, obesity, hypertension, and arthritis. Among the elderly, relatively high percentages have never received Pap tests to detect cervical cancer and do not have health insurance.

- **White Women**

White women had the second shortest life expectancy. They were at greater risk for death due to breast cancer and suicide than were other women. Among elderly women, whites had elevated risk of death due to falls and chronic obstructive pulmonary disease.

- **Women of Childbearing Age**

Women of childbearing age have increased need for medical services, because of their need for care during pregnancy and childbirth, and increased need for economic resources to care for their families. However, they were more likely to be poor and more likely to lack insurance coverage than women past their childbearing years. Furthermore, compared with women of childbearing age who did not give birth, new mothers were more likely to live below the poverty line and to have less than a high school education.

Over half of the women with children were in the work force, even if their children were

preschool-aged. Women with family responsibilities who also work by definition have two jobs and are at risk for stress-related problems, unless they have adequate assistance. They also have limited time for health promotion and disease prevention activities.

- **Senior Women**

The senior women are most at risk for sickness and death. Almost half in this age group reported that they had been diagnosed with hypertension, about one quarter were obese, and about 60 percent had arthritis. Fortunately, nearly all had health insurance because of the Medicare Program. Nearly half of the senior women in California were widowed and over half had incomes in the poverty range, putting them at risk for inadequate housing (which increases the risk of falls), poor nutrition (which contributes to bone disorders, difficulty managing diabetes, obesity, and cancer), and difficulty with transportation for medical visits or to shop for necessities.

Seniors were more likely than younger women to have limited formal education, especially among Hispanics and African Americans. These limitations may make it more difficult for them to receive and understand health-related information such as: notices about immunization services to prevent influenza and pneumonia; directions for the correct use of prescribed medications in order to prevent hospitalization for adverse reactions; or instructions from their providers.

Emerging Problems

In this report we identified a number of emerging problems that are likely to cause an increasing burden of illness among women in California and an increasing need for health care services.

- **Aging of the "Baby Boom"**

Women who were born in the post World War II "baby boom" had reached ages 35-45 during the period covered by this report. They will reach age 55-65 in 2010 and age 65-75 by 2020. The resulting increase in the number of elderly women is likely to lead to dramatic increases in the need for medical services for the health problems that impact the elderly, such as heart disease, cancer, falls, COPD, pneumonia/influenza, and adverse drug reactions. There will also be an increase in the need for screening services related to these illnesses, particularly mammograms and Pap tests, blood pressure screening, and testing blood glucose levels and bone density.

In this report, we found that women over age 65 were more likely to be poor, be widowed, and have restricted mobility than were younger women. As the size of the elderly population increases, there will be an increased need for programs to ensure adequate housing and nutrition among the elderly, as well as increased need for services to assist with routine activities such as shopping for necessities, cooking, and traveling to medical appointments.

- **AIDS**

Female mortality due to AIDS increased significantly in women of all race/ethnic groups, particularly among African American women. According to the Office of AIDS,

California Department of Health Services, "The female proportion of total AIDS cases in California increased steadily from 2 percent in the early 1980's to over 8 percent in 1993..." (p. 5.1, *Epidemiologic Overviews of HIV/AIDS Among Racial/Ethnic Communities in California, With a Special Supplement on HIV/AIDS Among Women*). It is essential to recognize the changing face of the AIDS epidemic in California and adjust services, outreach, and research policies accordingly.

- **Obesity**

Obesity was the only behavioral risk factor that showed a significant increase among California women during the past decade, in spite of intense media and medical promotion of the health and beauty benefits of being slim. The increase was greatest among African American and Hispanic women. Increasing prevalence of obesity merits serious attention because it is an important risk factor for the leading causes of hospitalization and death among women, including: heart disease, stroke, some cancers, and diabetes. The high prevalence of obesity in middle aged women in the 1990s is likely to result in increases in the prevalence of heart disease and other obesity-related illnesses among elderly women after 2010, as these women age. This would reverse the downward trend in cardiovascular disease observed during recent decades.

Need For Further Study

- **Collecting and Reporting Data For Asian Sub-populations**

In this report, as in the *Analysis of Health Indicators for California's Minority Populations* prepared by the Center for Health Statistics in 1994, it is clear that the natality, illness and mortality patterns of Southeast Asians are substantially different from those of other Asian groups, such as the Chinese and Japanese. It is essential that health-related data--including births, deaths, hospitalizations, and communicable disease cases--be reported in a way that permits differentiation among these groups. It is also essential that population estimates for these groups be routinely specified. Lacking this information, it is difficult to carry out the necessary public health planning related to Asian women.

- **Collecting and Reporting Data For Native Americans**

Native American women appear to be a high risk group. As with Southeast Asian women, it is important to make every effort to report both their health data and population estimates separately. In population surveys it is important to obtain sufficiently large samples of Native Americans so that valid and reliable estimates of their health risk can be made.